DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
REQUEST FOR EXCEPTION TO POLICY (ETP)
FOR USE OF RESTRICTIVE PROCEDURES

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

LAST NAME	FIRST	MIDDLE	BIRTHDATE	COMMUNITY PROTECTION PARTICIPANT ☐ Yes ☐ No

ADDRESS	CITY	STATE	ZIP CODE

PROCEDURE(S) FOR WHICH EXCEPTION IS REQUESTED

Does this person have a legal guardian? ☐ Yes ☐ No

If yes, answer the following:

LEGAL GUARDIAN'S NAME	TELEPHONE NUMBER (INCLUDE AREA CODE)

AGENCY REQUESTING ETP

AGENCY'S NAME	TELEPHONE NUMBER (INCLUDE AREA CODE)

ADDRESS	CITY	STATE	ZIP CODE

ADMINISTRATOR'S SIGNATURE	DATE	PRINT ADMINISTRATOR'S NAME

DOCUMENTATION

Attach the following documentation per DDD Policy 5.15, Use of Restrictive Procedures:

☐ a. Definition of target behavior(s)
☐ b. Functional assessment or psychosexual evaluation
☐ c. Description of positive behavior support strategies
☐ d. Description of restrictive procedure(s)
☐ e. Data plan
☐ f. Monitoring plan and evaluation plan
☐ g. Written consent of the person
☐ h. Written consent of guardian
☐ i. Other (specify):

REGIONAL ADMINISTRATOR'S DECISION

☐ ETP approved for _____ months (not to exceed 12 months).
☐ Resubmit with modification(s) as specified (or attach additional sheet):_____

_____

☐ ETP not approved.

COMMENTS	SIGNATURE
	DATE